Revised 12/95

HEALTH CARE FINANCE AND SERVICE DELIVERY REFORM PROGRAM

COUNTRY ACTION PLAN

KYRGYZSTAN

Submitted to the
United States Agency for International Development
Regional Mission for Central Asia, Almaty, Kazakhstan
Under Contract No. CCN-0004-C-00-4023-00

Abt Associates, Inc.
55 Wheeler Street, Cambridge, MA 02138-1168

TABLE OF CONTENTS

Appendices

EXECUTIVE SUMMARY

The Health Care Finance and Service Delivery Reform Program (HCFSDR) is a three year NIS wide program, with an option of an additional two years. Approximately 32 percent (or $13.0 million) of the total three year program budget is allocated to the Central Asia Region countries of Kazakstan and Kyrgyzstan. This Country Action Plan provides the program strategy for Kazakstan.

Assessments carried out by the HCFSDR, other USAID-funded programs, and other donors, as well as the predecessor Health Finance Sustainability Project, have revealed a number of constraints that must be addressed in order to achieve substantive reform of the Kazakhstani health financing and service delivery systems. The major areas of constraint include decreased level of funding to the health care sector and inefficient use of available resources and lack of incentives to improve productivity.

The goal of the HCFSDR program in Kyrgyzstan is to strengthen the capacity to manage the human dimension of the transition to democracy and a market economy by improving the sustainability of social benefits and services.

The general program strategy is to parallel current economic reforms by creating competition among health care providers and increasing efficiency. The aim of the strategy is to improve the financial sustainability of the health care sector by increasing the efficiency and productivity of the health care sector.

To achieve improvements in efficiency, quality and access to health care services in Kazakstan, the program will focus its resources on achieving the following programmatic outputs:

1. New primary care practices established and existing primary care practices expanded and strengthened in the pilot area.

2. New provider payment methods developed and implemented in pilot area.

3. Improved quality assurance, financial and clinical information systems designed and tested in pilot facilities with new provider payment methods.

The total cost of the HCFSDR program in Kyrgyzstan, for the period 1/1/96 through 12/31/96, will be $1,389,000.

KYRGYZSTAN COUNTRY ACTION PLAN

GENERAL PROGRAM STRATEGY

Kyrgyzstan is a developed country experiencing a transition from a command to a market economy. The goal of the Health Care Finance and Service Delivery Program in Kyrgyzstan is to strengthen the capacity to manage the human dimension of the transition to democracy and a market economy by improving the sustainability of social services (Strategic Assistance Area 3 and Program Objective 3.2).[1]

The program strategy is to parallel current economic reforms by creating competition among health care providers to increase the efficiency of the health sector. To create a market in health services, fundamental relationships must be changed between the government, facilities, physicians, and consumers to establish economic incentives.

The constraints to achieving the program goal are: 1) concentration of health sector resources in the hospital sector; and, 2) inefficient use of available resources and lack of incentives to improve productivity[2]. Two development strategies will be followed to address the constraints: 1) enhancing the capability and effectiveness of the primary care sector (Section I of plan); and, 2) increasing the efficiency and productivity of the health care sector (Section II of plan).

The program will focus its limited resources and time on achieving the following outputs with the anticipated impact of improved efficiency, quality, and access to health care services:

1. New primary care practices established and existing primary care practices expanded and strengthened in the pilot area.

2. New provider payment methods developed and implemented in pilot area.

3. Improved quality assurance, financial and clinical information systems designed and tested in pilot facilities with new provider payment methods.

---

[1] The entire project addresses Program Objective 3.2 and the impact indicator "improved efficiency, quality and access to health care". For simplicity of presentation, the plan document does not repeat the Program Objective and impact indicator for each output.

[2] There are other health sector problems, including a decreased level of funding to the health care sector and an acute shortage of pharmaceuticals, equipment and supplies. These shortages have occurred partly as a result of the overconcentration of resources placed in staff and beds. The World Bank, WHO, GTZ and other foreign donor organizations are addressing the pharmaceutical sector and equipment problems.

Resources are allocated almost exclusively to an intensive demonstration site in Issyk-kul Oblast where comprehensive health reforms are being implemented. The World Bank is finalizing a health sector loan which will extend the provider payment reforms to Bishkek City and Chui Oblast.

I. Primary Care

Constraint: Concentration of health sector resources in the hospital sector.

Output 1: New primary care practices established and existing primary care practices expanded and strengthened in the pilot area.

This output meets the Strategic and Program objectives by decentralizing the health sector and restructuring the primary care sector to create competitive conditions that encourage the provision of more efficient and cost-effective health care.

A fundamental problem in the Kyrgyzstan health sector is the overdevelopment of the hospital sector relative to the primary care sector. Although primary care is the most cost-effective method for treating the majority of medical conditions, 70-80 percent of health resources go to hospital care. Only 30-35 percent of the country's physicians provide primary care, compared to 60 percent in Germany and the U.K.

The majority of the existing primary care physicians are based in polyclinics where the financial and organizational structure provide little incentive to treat patients, instead they are referred to polyclinic or hospital specialists. The extremely high referral rates and overspecialization of physicians has created an inefficient service delivery system providing poor continuity of care.

To increase efficiency and reduce health care costs, the polyclinic system needs to be restructured to allow greater financial and management autonomy for primary care practices. Introduction of new payment systems (see section II) will create incentives for primary care physicians to increase their patient load and reduce referrals to specialists.

The major structural change required in the health care delivery system will be accomplished through the formation of small primary care group practices called Family Group Practices (FGP's). Currently, there are very few general or family practitioners. A group consisting of a therapist (internist), pediatrician, and obstetrician/gynecologist is required to provide comprehensive primary care services. In order to reimburse providers a capitated rate for the provision of all primary health services to an individual, a entity capable of providing the entire range of primary health services must exist.

The primary care groups will be the focal point of the new provider payment methods -- they will enroll people and receive a capitated rate for providing a specified set of health services. The financial incentive for the groups is to increase their patient load and reduce referrals to specialists.

The combination of management autonomy and new financial incentives will provide a catalyst for the creation of new FGP's and increase the number and quality of primary care physicians.

Different models of primary care should be encouraged, and over time clinical retraining and new medical institute curriculum will lead to the development of general and family practitioners. The primary care groups should be independent, form voluntarily, and be organized as a business. They can initiate the development of non-profit entities within the health sector and also become private practitioners.

One of the primary reasons for high referral rates is that primary care units are lacking even the most basic clinical equipment, which greatly limits their ability to diagnose and treat outpatient cases. To increase clinical capability, primary care units need to be provided with basic clinic equipment and physicians and nurses require short-term refresher training in management of outpatient cases. New locations for FGP's dispersed throughout the community need to be identified and minor facility modifications can be made to establish the FGP's as distinct, independent units from the polyclinics.

Currently, 16 FGP's exist in the initial demonstration area of Karakol and the surrounding three rayons.[3] The project will support all activities required to establish additional FGP's including:

1. Continued technical assistance to the Family Group Practice Association established in July, 1995.

2. Coordination of voluntary formation of physicians into FGP's.

3. Identification and determination of locations for FGP's, providing a separate identity in the community, including minor renovations.[4] This element also includes determination of policies on leasing publicly owned health premises to FGP's, and initiation of a process to establish PCGP's as independent entities.

4. Provision of clinical equipment for FGP's to enable the groups to treat patients rather than refer them. This includes both coordinating inventory and reallocation of existing equipment and procurement of new equipment.[5]

5. Provision of clinical training to increase the capability of FGP's to manage patient care on an outpatient basis.

6. Establishment of financial and clinical information systems, including development of a cadre of practice managers providing business skills for the groups.

---

[3]The Issyk-kul demonstration site initially consisted of Karakol and three surrounding rayons. It was expanded to include the entire oblast (two additional rayons) in the fall of 1995.

[4]A ZdravReform Program grant provided $8,500 for minor renovations to FGP's.

[5]Mercy Core International/Kyrgyzstan provided a grant of $16,000 to provide equipment for 16 FGP's. A ZdravReform Program grant of $16,000 provided equipment for an additional 16 FGP's, so that equipment is provide to all 32 FGP's being established in Phase I.

FGP's with sufficient capacity to serve the entire oblast population will be established, with each FGP serving approximately 4,500 individuals. The remaining FGP's will be formed in three phases: 1.) another 16 FGP's for which equipment has already been approved in Karakol and the surrounding three rayons; 2.) expansion of the number of FGP's in Karakol and the surrounding three rayons to the total of 55 required to serve the population of approximately 250,000 people; and 3.) expansion to the entire oblast for a total of approximately 100 FGP's serving 440,000 people.

Polyclinic specialists who do not desire to join an FGP and ancillary services such as radiology and labs, will remain in polyclinics and they may compete with hospital outpatient departments or private entities to provide services to FGP's. Rationalization of the polyclinic structure is required to convert to FGP's and reduce excess capacity in the remaining polyclinics (see section II).

A key step in the development of the primary care sector is free choice of primary care provider by the population and enrollment of the entire population into primary care groups. Participation by the population in decisions about their health care gives providers an incentive to provide high quality services. If patients are not satisfied, they can change providers. Information will be provided to the population to help them make informed choices about their medical provider. Consumer information and provider choice will create competition among primary care providers and improve quality by making providers accountable.

The project's marketing group has completed a public awareness campaign to inform the population about PCGP's and their right to choose their physician. Future marketing group activities will support: 1.) A marketing campaign to advertise enrollment day and the actual enrollment process including development of an enrollment database; and, 2.) On-going public education, and distribution of comparative information so the population may judge provider performance.

The targets to be used to measure progress toward Output 1 are:

1. **Number of FGP's formed increases from 16 in 12/95 to 55 by 12/96, and the percentage of the eligible population enrolled in FGP's increases from 0% in 12/95 to 50% of the oblast population by 10/96.**

2. **A 20% reduction in the referral rate of primary care physicians, from approximately 60% in 12/95 to 50% by 10/96.**

Specific Activities and Completion Date:

1. Phase I of FGP's established consisting of 32 FGP's. (March 1996).

2. Phase II of FGP's established consisting of a total of 55 FGP's (July 1996).

3. Financial and clinical information systems for FGP's developed and implemented (October 1996).

4. Phase I of marketing campaign completed with the population enrolled in 32 FGP's (May 1996).

5. Phase II of marketing campaign completed with the population enrolled in 55 FGP's (September 1996).

6. Public education and comparative information program for FGP's completed (November 1996).

7. Small grants allocated to equip new primary care practices (May 1996) (Grant process detailed in section V)

II. HEALTH SECTOR FINANCING AND EFFICIENCY

Constraint: Inefficient use of available resources and lack of incentives to improve productivity.

Output 2: New provider payment methods developed and implemented in pilot area.

This output meets the strategic and program objectives by changing the economic incentives of the health sector to encourage more efficient provision of quality health services.

Payment Methods

Resources are allocated inefficiently in the health sector largely due to the financial incentives for facilities contained in the current payment system. Both hospitals and polyclinics are paid using a budget system in which the facilities are allocated a fixed amount of funds to operate for a year. The budget is inflexibly partitioned according to budget chapters. As the budget system allocates funds based on production input measures such as number of beds, it contains a direct financial incentive to increase and maintain capacity. The result is a health service delivery system with too many hospitals, and too many beds. The excess bed capacity leads to high fixed costs in the health sector.

This form of payment provides no incentives for efficiency, and in so far as the chapters prevent the flexible use of funds, the payment system actually inhibits the efficient use of resources.

The objective of payment reform is to shift resources from the hospital to the primary care sector and to increase the technical efficiency of both sectors. New payment systems for hospital care, primary care, and outpatient specialty and ancillary services would create financial incentives for all providers of health services to manage care provided to patients more efficiently and cost-effectively while maintaining or improving the quality of health services provided to the population. Decision-making on the allocation of resources would be decentralized so that both providers of health services and the population have more responsibility and accountability for the efficient provision of high quality health services.

Payment for care would no longer be made on the basis of production input measures but rather on the basis of performance as measured by services provided to patients, or episodes of care completed. The new provider payment methods would strengthen the connection between the quantity and quality of services provided, and the financial reimbursement received for those services. Incentives would encourage treatment of patients on an outpatient as opposed to inpatient basis, reduce length-of-stay for those patients who do require hospitalization, and reduce unnecessary referrals to specialists and for diagnostic tests.

Provider payment reforms would change the financing and the organization of care in two important ways. Payment for care would be separated from delivery of care. The payer would focus on paying for the best care at the lowest cost -- it would purchase care rather than maintain facilities. The provider would have more flexibility to focus on delivering the most optimal mix of services with the best outcome. Secondly, providers would be "at risk" in that they would now be responsible for differences between payments received and costs incurred. Providers would be accountable for more efficient and higher quality of care.

Benefits resulting from achieving the goal of increasing the efficiency of the health care sector include the following:

1. Ability to provide more health services with current funding levels due to more efficient allocation of existing health sector resources.

2. Increased confidence in the health sector by businesses and the population leading to greater willingness to invest in health.

3. Increased responsibility and accountability of health providers for the outcome of health services provided to the population.

4. Increased consumer participation in decisions about their health care.

5. Improvements in the quality of health services.

6. Increased access to health services for the population.

7. Greater satisfaction and prestige for medical professionals, including attracting and keeping quality professionals.

In the hospital sector, the payment method would change from norms based on the number of beds to a case-based payment system. Market oriented hospital payment systems typically provide a payment for the production of a defined unit of hospital output. A case-based system provides a payment for each discharge from the hospital -- intended to be equal to the average cost of producing a unit of output in an efficient hospital. Hospitals are reimbursed a prospectively determined amount for each patient discharged, adjusted for the type and complexity of illness. The hospital payment system will only include operating costs. Capital investments will continue to be centrally allocated and can be used to enhance competition among providers. Finally, the hospital payment system requires the development of a health price index which can be used to update the payment rates for providers.

Efficiency will improve as hospitals respond to incentives to keep patients in the hospital for less time and shift non-acute patients into primary care and sub-acute facilities. The hospital payment system must be closely coordinated with a rationalization and restructuring plan. This is important because closing hospitals will help align the competitive system and create savings which can be reinvested in the hospital payment system. Real savings come from closing hospitals, not just reducing beds because of the high level of fixed costs, such as utilities, in the system.

Providing incentives for efficiency is useless unless managers are simultaneously given authority and the ability to reduce costs. The case-based hospital payment system assumes that managers of individual hospitals will have control over staff hiring, firing, salary decisions, and purchases of drugs, supplies, and all other items needed by the hospital.

In the primary care sector, polyclinic budgets are based on staff and capacity, creating incentives to increase capacity rather than provide quality services. Physicians are salaried and underpaid; lacking incentives to increase income, they act as indifferent dispatchers referring patients to hospitals, further increasing hospital costs. Physician payment methods need to be changed from that of norms based on number of visits to capitation (predetermined fee per individual for provision of a defined set of health services).

The project would implement a fundholding system with FGP's as fundholders receiving a capitated rate for each person enrolled. They would provide all health services required by their enrollees either directly or by purchasing them from specialists, diagnostic facilities, or hospitals. PCGP's would have the right to refer to any accredited specialist or facility. The fundholding system would accomplish the objective of moving health resources to the primary care sector, as FGP's would become the clinical and financial center of the health delivery system. Under a capitated payment system, productivity will increase and referral rates will decrease. As with hospital payment, changes in payment methods need to implemented simultaneously with rationalization and restructuring of polyclinics and creation of FGP's (see section I).

Basic Health Insurance Fund

Kyrgyzstan is currently experiencing a crisis in funding the health sector. Even before the break-up of the Soviet Union, the percentage of the GNP devoted to health was significantly less than other industrialized countries. The situation has significantly deteriorated since independence. The percent of public health expenditures to GDP declined from 4.2 % of GDP in 1990 to 2.6 % in 1993, with an increase to 3.9 % in 1994.[6]

A concern of the health sector is how to generate additional resources for health care that are independent of the state budget. The Health Protection Act and Law on Medical Insurance, signed into law in July, 1992 provides for diversification and decentralization of revenue sources, making the financing of health care no longer solely reliant on general government revenues. At least one Basic Health Insurance Fund (BHI) can be created in each oblast, to be financed through multiple sources of revenue.[7] Design of a realistic minimum benefits package and user fees by the BHI fund

[6] The GDP in 1994 is only 50 percent of the 1990 level.

[7] Sources of revenue include:
- a new, minimum 6% payroll contribution paid by employers.

will decrease the level of government support and facilitate the development of private insurance for supplemental benefits not contained in the minimum benefits package.

At the request of the Ministry of Health (MOH), the Project is assisting in designing and implementing the health insurance program in Issyk-Kul Oblast, the MOH designated "experimental zone" for health insurance.[8] In addition, a World Bank project to extend the provider payment reforms in Issyk-kul to Bishkek City and Chui Oblast is in the final stages of development with a projected starting date of July, 1996. It is a condition of negotiations for this loan that the Government of Kyrgyzstan remove all legal and regulatory obstacles to the implementation of provider payment reforms in Issyk-kul (negotiations are expected to occur in February, 1996). Although ZdravReform personnel have been continuously interacting with the government concerning legal issues, this additional leverage should help ensure that new provider systems are implemented early in 1996.

Currently, national, oblast, municipal, and rayon governments all finance and control their own facilities using a budgetary system. The health reforms envision the population choosing providers and providers receiving payment for specific services provided to patients. The focus of payment for health services changes from the facility level to the patient level. The fundamental purpose of the BHI fund is to serve as a structural mechanism to institute health care reforms. It will serve as a fiscal intermediary, pooling the funds from the national, oblast, municipal, and rayon sources and reimbursing providers for health services they provide to the population. Funds would no longer be delineated by government level and separately allocated to facilities; services would be purchased by the BHI fund from one pool of funds.

The BHI fund requires institutional capacity to pool the funds and manage the new provider payment systems. The development and installation of new computer systems is especially important. Provider payment on a treated case basis increases the base unit for reimbursement many times. For example, in Issyk-kul, the base unit for hospital payment will increase from budgets for about 50 facilities to payment for about 50,000 treated hospital cases. This very large increase in the number of transactions requires the development of automated systems to manage the payment process.

Computer systems would handle enrollment of the population, construction of rates for the payment systems, recording of clinical information from facility bills, payment of providers for services, operation of a quality assurance system, and analysis of health statistics. An accounting system would record all financial transactions from defined source payment documents, interact with the banking system and provide financial reports for the fiscal intermediary. Current accounting systems provide a good starting point; however, they could benefit from the introduction of accrual accounting and more sophisticated financial reporting to present available information in a more useful form. Internal auditing and control procedures are necessary. Relationships between the BHI fund and the treasury and banking system need to be clearly

---

- a capitated rate by the oblast government into the fund to cover non-working and exempted populations not contributing through the employer payroll -- employees of "public budget organizations" (e.g. schools and hospitals), elderly, unemployed, disabled, women and children.
- funds from the current 34.5% Social Insurance and Pension Fund payroll tax, which are currently used for payment of temporary and permanent disability, social security, other forms of cash assistance, and health.

[8] The GOK decided to test its legislated financing and delivery system reform model in one geographic area, Karakol and three surrounding rayons within the Issyk-Kul oblast, before expanding the reforms nationwide. In March, 1995, a ministerial decree was passed officially establishing the BHI in Issyk-Kul oblast and giving greater authority to the local health administration to implement the BHI.

defined. The transition to a stable market economy may require the banking system to gradually shift its focus toward handling financial transactions efficiently, away from serving as a control mechanism.

To date the project has completed the following activities:

1. Evaluated the legal environment for the BHI fund and prepared a draft Presidential decree and Government edict to address legal and regulatory issues.

2. Prepared preliminary regulations for the BHI fund.

3. Helped define the organizational structure for the BHI fund.

4. Developed and assisted in the implementation of a facility rationalization plan. The rationalization resulted in savings of 1.62 million soms, closure of 6 facilities, and a reduction in oblast beds of 9.2%.

5. Developed a hospital payment system. The system was based on a comprehensive database which includes all hospitals in the demonstration area.

6. Designed a complete computer and accounting system for the BHI fund and developed and installed the first module -- an enrollment database for FGP's.[9]

7. Developed a preliminary capitated rate and design of the fundholding system for FGP's.

The targets to be used to measure progress toward Output 2 are:

3. Reduction of hospital admission rate and length of stay by 20% by 10/96.

4. Reduction in the number of hospital beds by 10%, from 3880 in 12/96 to 3545 by 10/96.

Specific Activities and Completion Date:

1. Finalize the organizational structure, staff positions and regulations for the BHI fund (March 1996).

2. Complete development, installation and training for the computer system modules, accounting and auditing system, and banking relationships for the hospital payment system (April 1996).

3. Pool funds and implement the hospital payment system (May 1996).

[9]Mercy Core International awarded a grant of $20,000 to the BHI Fund to purchase a computer network for their management information system

4. Complete design of the FGP fundholding system, including a fee schedule for outpatient specialists and diagnostic tests (March 1996).

5. Complete development, installation and training for the computer system modules, accounting and auditing system, and banking relationships for FGP fundholding (June 1996).

6. Develop and implement Phase I of the capitated rate and fundholding system for 32 FGP's (July 1996).

7. Develop and implement Phase II of the capitated rate and fundholding system for 55 FGP's (October 1996).

8. Develop and implement Phase II of the rationalization and restructuring plan for hospitals and polyclinics (November 1996).

Output 3. Improved quality assurance, financial and clinical information systems designed and tested in pilot facilities with new provider payment methods.

The complexity and importance of the provider payment systems requires creation of an enabling environment for successful implementation. Components of this environment are financial systems, health facility autonomy, and quality assurance systems.

A legacy of central planning is that health facility managers have little information on the true costs of producing health services in their facilities. Adapting to the incentives of the new provider payment systems requires the tools of financial systems (mainly accounting and cost accounting) and clinical information systems to provide facility managers with information to make good decisions about the type and mix of services produced by the facility. In addition to internal management support, the accounting and clinical information systems will be used in the billing system for hospital payment and to provide the BHI fund with information required to set payment rates.

Currently, there is no formal system of quality assurance to guarantee that facilities meet minimum basic standards. A system of quality assurance is essential to monitor care and prevent "gaming" or abuse under the different financial incentives of new provider payment systems. Under FGP fundholding, for example, there will be an incentive not to refer patients. For hospitals, a case-based payment system will create incentives to admit patients unnecessarily and to discharge patients early. The quality assurance system is needed to closely monitor hospital admissions and discharges. In addition to quality assurance, a basic licensing and accreditation system will ensure that health facilities meet financial, management and clinical standards necessary to operate.

Finally, health facility autonomy is required to create competitive conditions within the health care sector. Health facilities are tightly controlled financially by the Ministry of Finance (MOF) and organizationally and medically by the Ministry of Health (MOH). Decentralizing control of health care facilities would allow managers the flexibility they need to adapt to a changing environment and allocate resources more efficiently. In addition, improvements in the national budget allocation process for the health sector would also increase facility autonomy.

To date the project has completed the following activities:

1. Development and training for a facility cost accounting system.

2. Assessment of quality assurance and development of a Clinical Practice Improvement Program.

3. Development of a licensing and accreditation system.

4. Training of government officials, facility managers, economists and accountants on business management principles.

The targets to be used to measure progress toward Output 3 are:

1. **Number of health care facilities in pilot area with improved quality assurance systems increased from 0 in 12/95 to 20 by 10/96.**

2. **Number of health care facilities in pilot areas with improved financial and clinical information systems for resource management increased from 0 in 12/95 to 20 by 10/96.**

Specific Activities and Completion Date:

1. Complete development, installation, and training for a facility clinical information system and operational procedures to submit bills for services to the BHI fund (April 1996).[10]

2. Refinement, implementation and training for the quality assurance program at both the BHI fund and individual facility level (July 1996).

3. Cost accounting systems, clinical information systems and financial systems installed in health facilities and key personnel trained. (September 1996).

4. Implementation of a licensing and accreditation program to determine the capability of a facility to provide high quality services (October 1996).

5. Creation of a legal and regulatory framework for management autonomy and on-going training for facilities (November 1996).

IV. MONITORING AND EVALUATION

[10]Activities 1 and 3 depend on the disposition of the IRM plan for computers which was submitted in August, 1995.

The program will measure implementation progress through a monitoring and evaluation database which will track results of all activities as they relate to the three intended outputs. Data on the program indicators will be periodically collected, i.e. bi-annually, through report and record reviews, surveys, and site visits to document progress.

Routine reporting and monitoring functions will be carried out using a standardized format, reporting progress against targets. Reports will be submitted on a weekly basis, with bi-annual summaries generated for the Monitoring and Reporting System.

Specific Activities and Completion Date:

1. Project reports submitted bi-annually to USAID/CAR. (Feb., Aug.,1996)

2. Monitoring and evaluation activities carried out to measure progress in achieving outputs and impact indicators. (Dec., 1996)

IV. GRANT PROGRAM TO SUPPORT NON-GOVERNMENTAL SERVICES AND INNOVATIVE REFORMS IN FINANCE AND SERVICE DELIVERY

This section outlines the process for awarding grants, the grants are included as specific activities in the health sector financing and health sector efficiency sections.

The absence of alternatives to the government health system limits innovation and restricts competition and consumer choice. The expected result of ZdravReform small grants program is the expansion of health care reform initiatives and increased practical experience and support for reform-minded individuals and institutions. The total amount budgeted for grants is $45,000, with an estimated 3 grants to be awarded in the Issyk-Kul demonstration site.

A Grants Program Management Manual describes the procedures that will be used to award grants on the following schedule:

1. Assistance to prospective grantees in preparing new grant applications. (Fe. 1996)
2. Grant applications reviewed by Grants Committee (Mar. 1996)
3. Grants awarded. (May, 1996).

VI. COORDINATION WITH OTHER HEALTH SECTOR DONORS AND USAID PROJECTS

The program will collaborate with other donors to increase the impact and synergy of reforms in the health sector. Areas of activity coordination and collaboration are as follows:

Primary Care:

USAID --

Other Donors -- World Bank (see below), Mercy Core International, World Health Organization/MANAS, ODA, GTZ, and a few NGO's providing clinical training in Bishkek.

Health Sector Efficiency:

USAID -- Privatization Contractors

Other Donors -- World Bank, Mercy Core International, World Health Organization/MANAS, ODA, GTZ.

A World Bank Loan proposal is currently being finalized in which the health finance reforms implemented in the pilot area under this Project will be extended to Bishkek City and Chui Oblast. The World Bank project would focus on replicating provider payment reforms through incentive-based payment systems, as well as ZdravReform initiatives in improving facility autonomy, management and information systems and quality assurance systems. The provider payment reforms are intended to reinforce other components of the World Bank project including drug procurement, facility rehabilitation, and improved outpatient practice protocols. Under the loan, an estimated $4 million will be expended on technical assistance, training, and commodities over a four year period, beginning in late 1995. Coordination of efforts between the ZdravReform and the World Bank on extension of the pilot area reforms have great potential to maximize the impact of pilot area activities. World Bank leverage can serve to accelerate national and local reform measures in a wide variety of areas as well as remove legal and regulatory obstacles. Conversely, tested ZdravReform products will enhance the success of the roll-out to Bishkek City and Chui Oblast.

Technical Assistance Requirements for ZdravReform Program
January - December, 1996

A. New Provider Payments

Provide follow-on technical assistance to the oblast BHI Fund to finalize the organizational structure, staff positions and regulations, including regulations that will establish the pooling of funds and enable implementation of the new payment systems. Assistance will also be provided to complete design of the FGP fundholding system, including a fee schedule for outpatient specialists and diagnostic tests; to develop and implement Phase I of the capitated rate and fundholding system for 32 FGP's; develop and implement Phase II of the capitated rate and fundholding system for 55 FGP's, and; develop and implement Phase II of the rationalization and restructuring plan for hospitals and polyclinics.

Estimated LOE: 5 PM Estimated Cost: $125,000

B. Primary Care

Provide continued technical assistance to the oblast health department and Family Group Practice Association to coordination of voluntary formation of physicians into FGP's, identify and determine locations for FGP's, arrange for leasing publicly owned health premises to FGP's, and initiation of a process to establish FGP's as independent entities, and coordinate the equipping and renovation of FGP clinic sites. Assist potential grantees in applying for grants to support the establishment of new FGPs. Continue to provide short-term local clinical training to FGP staff and to establish financial and clinical information systems, including development of a cadre of practice managers providing business skills for the groups.

Technical assistance will also be provided to the ZdravReform marketing group to support the marketing campaign to advertise enrollment day and the actual enrollment process including development of an enrollment database; on-going public education, and distribution of comparative information on provider performance.

Estimated LOE: 6 PM Estimated Cost: $150,000

C. Quality of Care

Technical assistance will be provided to refine, implement and train personnel for the quality assurance program at both the BHI fund and individual facility level; to assist in implementation of a licensing and accreditation program in the pilot area; and to draft legal and regulatory documents to establish management autonomy. Follow-on training in the quality assurance programs will be conducted for facility personnel.

Estimated LOE: 4 PM Estimated Cost: $100,000

D. Infrastructure Development

Provide technical assistance to complete development, installation and training for the computer system modules, accounting and auditing system, and banking relationships for the hospital payment system; and to complete development, installation and training for the computer system modules, accounting and auditing system, and banking relationships for FGP fundholding.
Assistance will be provided to complete development, installation, and training for a facility clinical information system and operational procedures to submit bills for services to the BHI fund.

Estimated LOE: 4 PM Estimated Cost: $100,000

E. Information Dissemination

Continued dissemination of information and products resulting from project activities will be carried out at the national and oblast level. Assistance will be provided in "packaging" and production of information materials and conducting of in-country training workshops and courses for local counterparts. Information dissemination activities will involve all of the project activity areas. A second regional technical conference will also be held, if funding permits, in which local counterparts will present and share information on their reform activities.

Estimated LOE: 1.5 PM Estimated Cost: $34,000

Total Estimated LOE: 20.5 PM Estimated Cost: $509,000

Budget D. FY 1996 & FY 1997 (Oct-Dec)											
Budget Plan Oct. 1, 1995 - Dec. 31, 1996											
Assumption: FY 1996 Obligated Funds =			**1,800,000**								
Background:		**Kazakstan**		**Kyrgyzstan**		**Uzbekistan**		**Turkmenistan**		**TOTAL**	
Obligated		5,868,063		1,620,540		500,000		250,000		8,238,603	
Expended 9/30/95		4,014,716		998,687		88,899		95,887		5,198,189	
Remaining 10/1/95		**1,853,347**		**621,853**		**411,101**		**154,113**		3,040,414	
Reobligate UZ & TK		**100,000**		**465,214**		*(Close-out)*		*(Close-out)*		565,214	
1996 FUNDS AVAILABLE		1,953,347		1,087,067						3,040,414	
1996 FY FUNDS OBligated		1,000,000		800,000							
US-Turkey Funds		655,000									
TOTAL		**3,608,347**		**1,887,067**						**5,495,414**	
1996 Budget Breakdown ($000's)											
		FY 96	FY 97	**FY 96**	FY 97						
Mgt, Admi, & Operating Costs											
Regional Office*		1050	262.5	545	136.25					1993.75	
Headquarters		275	61	164	26					526	
IDS Office		98	10	115	28.75					251.75	
Sub-total		**1423**	**333.5**	**824**	**191**					**2771.5**	
* Includes US advisors and Regional Office local technical consultants											
National Level - Technical Assistance											
Pharmacy Privatization		560	140							700	
Drug Info Sys/Formularies		95	23.75							118.75	
New Provider Payments		50	12.5							62.5	
Quality of Care		50	12.5	103						165.5	
Infrastructure Development		25	6.25							31.25	
Information Dissemination		44	11	36	9					100	
Sub-total		**824**	**206**	**139**	**9**					**1178**	
Oblast Level - Technical Assistance, Grants, Commodities											
Health Insurance		5		5							
New Provider Payments		200	75	125	42					442	
Quality of Care		175	25	95	5					300	
Primary Care				150	32					182	
Infrastructure Development		60	15	100	25					200	
Information Dissemination		13	3.25	5						21.25	
Small Grants Program		170		70						240	
Commodities - Computers		80		70						150	
Sub-total		**703**	**118.25**	**620**	**104**					**1545.25**	
Grand Total		**2950**	**657.75**	**1583**	**304**					**5494.75**	

REGIONAL OFFICE and IDS TEAM RESPONSIBILITIES													
Staff		**Area of Responsibility**											
		Mgmt.	**Admin.**	**Pharmacy**	**Drug Info**	**Payment**	**Quality o**	**Primary**	**Infrastruc**	**Grants**	**Private**	**Rational-**	**Inform.**
Regional Office				**Privatize**	**Formulary**	**Systems**	**Care**	**Care**	**Develop.**		**Practice**	**ization**	**Dissemin**
US LTA													
Borowitz		X		X	X	X	X	X				X	X
Copeland		X	X							X		X	X
O'Dougherty						X		X	X			X	X
Slaski			X							X	X		
Krakoff				X	X						X		X
Local Technical Staff													
Kayrgeldin			X										
Poltorkina			X			X							X
Danilenko							X						X
Almagambetova					X		X	X					
Karakoulov				X	X								
Kutanov						X			X				
Timoshkin						X			X				
Siderenko						X			X				
Sukurov										X			
Nugumenova					X		X						X
Kelezbek					X								
Nurzhanov					X		X						X
Issyk-Kul IDS Office													
US LTA													
Millslagle		X					X	X		X		X	X
Local Technical Staff													
Mukanova			X					X					X
Ismailova						X	X		X			X	X
Ibragimov								X					X
Abdrakhmanov			X						X	X			
Ahmatov								X					X
South Kazakstan Office													
Local Technical Staff													
Miglina		X	X							X			X
Samchenko					X	X	X				X		X